

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

32922

State File No.

RECEIVED OCT 1 1952

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8754	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital				d. STREET ADDRESS (If rural, give location) 4100 Rosa			
3. NAME OF DECEASED (Type or Print) Mamie Eyermann		a. (First)		b. (Middle)		c. (Last)	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 6, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Wm. Hammerschmidt		13b. MOTHER'S MAIDEN NAME Sophia Spellmeyer		14. NAME OF HUSBAND OR WIFE Gottlieb Eyermann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gottlieb Eyermann 4100 Rosa			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Hypertension Arteriosclerosis DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 6 hours unk unk	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK		21f. HOW DID INJURY OCCUR?		331X			
22. I hereby certify that I attended the deceased from Sept 14, 1952 to Sept 16, 1952 that I last saw the deceased alive on Sept 16, 1952 and that death occurred at 11:52 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE Robert S. Swaine		(Degree or title) M.D.		23b. ADDRESS Paul Brown Bldg. St. Louis		23c. DATE SIGNED Sept 18-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-19-52		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo	
25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home		ADDRESS 6322 S. Grand Blvd.					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. R. G. Warner,
Paul Brown Bldg.

11 to 1 p.m.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Student Embalmer No. _____

Licensed Embalmer No. 4242

P. O. Address 6322 80th Street

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.